

College and Post-Secondary Immunization Record



Student: Complete the top portion and have the remaining portion completed by your Health Care Provider

Name: _____

 Last First M.I. Suffix

Address: _____

 Street City State Zip Code

Date of Birth: ____/____/____ **Student ID #:** _____ **Date of Enrollment:** ____/____/____
 Month Year

Vaccines	Dates Given	Requirements
Tdap or Td	Tdap ____ Td ____ #1 ____/____/____	1 Tdap/Td booster within last 10 years
MMR	#1 ____/____/____ #2 ____/____/____ OR Positive Titer Dates: ____/____/____ ____/____/____ ____/____/____ Measles Mumps Rubella	2 doses or positive titers Minimum of 4 weeks between doses 1 st dose given after 1 st birthday
Meningococcal	1 st year in campus based housing? No ____ Yes ____ (needed) #1 ____/____/____	One dose for first year students living in campus based housing
Varicella	1. History of disease: Yes ____ No ____ (if no proceed to #2) Must sign Vt. Dept of Health "Documentation of Varicella" Form 2. Immunization: #1 ____/____/____ #2 ____/____/____ OR Positive Titer Date: ____/____/____	2 doses of varicella vaccine or history of disease or positive titer Minimum of 4 weeks between doses if age 13 or older (12 weeks for under age 13)
Hepatitis B	#1 ____/____/____ #2 ____/____/____ #3 ____/____/____ OR Positive Titer Date: ____/____/____	3 doses or positive titer Minimum of 4 weeks between doses 1 and 2 Minimum of 8 weeks between doses 2 and 3 (3 rd dose must be 16 weeks from first dose)

Health Care Provider Information:

Name: _____

Address: _____

Signature: _____ **Phone:** (____) _____

Please Return Completed Forms to:

Dean of Students
 College of St. Joseph
 71 Clement Road
 Rutland, VT 05701

Questions?

(802) 776- 5223 (Phone)
 (802) 776- 5275 (Fax)
 rlukaskiewicz@csj.edu